NEW YORK NEUROLOGICAL SOCIETY.

February 5, 1901.

The President, Dr. Joseph Collins, in the chair.

A CASE OF LOCOMOTOR ATAXIA TRAINED BY THE FRAENKEL METHOD.

Dr. A Wiener presented this man. He had been under this system of training for about one year, and while ataxia was still present, he had been very greatly improved, and was now able to go about even at night unaided. There had been no other treatment for the tabes.

SARCOMA OF THE BRAIN.

Dr. A. Wiener also presented a pathological specimen from a person, seventeen years of age, who had first come to him about November 1, 1898. There was an absolutely negative history of alcoholism and syphilis. About two years before this time the patient had suffered from a severe fright, and almost immediately thereafter had had a severe convulsion. Nothing further had been noticed until the summer of 1898 when she had suddenly developed a difficulty of speech, with right facial palsy. She had suffered from bad headaches frequently for three months previously. On coming under observation, there had been excruciating pain over the occipital region, complete deafness in the right ear and a bulging of the tympanic membrane. The right sterno-mastoid muscle had been in a state of constant contraction, and there had been a double optic neuritis, most marked on the right side. The voice was hoarse. Neither the upper nor the lower extremities had suffered any loss of power. There was no swaying when the eyes were closed, nor was there any bladder trouble. Her temperature was 100° F. The seventh, eight, ninth, tenth, eleventh and twelfth nerves were affected on the right side, and the sixth nerve on the other side. On November 8, a slight ptosis had been noticed, and the twelfth nerve palsy had become more marked. On November 28, there had been vomiting, vertigo and an increase in the ptosis of the left eye. On December 8 there had been complete third nerve palsy on the left side, and the headache had been very severe. Having diagnosticated a tumor of the

the brain, the patient had been sent to the Mt. Sinai Hospital. A mass had developed behind the ear, and on aspirating this it had been found that the case was one of congenital sarcoma. On January 11, 1899, the third nerve palsy had entirely disappeared on the left side, and the swelling behind the ear had grown larger. On January 21, the patient had suddenly become confused and blind in both eyes. In April it had been decided to open the mass to relieve the pain. By June 30 the patient had been up and around again. In October there had been a complete brachial plexus palsy on the right side. The tumor had kept on growing until almost the size of the patient's head. The patient had died on February 2, 1901, and an autopsy had been performed. The whole tumor had been found below and outside of the brain. In front was a large giant-cell sarcoma which had completely destroyed the sphenoid bone. At the back the tumor had destroyed the occipital bone. The brain was exhibited, and it showed that only the pons had suffered pressure. The tumor had apparently started in the mastoid portion of the temporal bone.

TENDON TRANSPLANTATION FOR DEFORMITY OF THE HAND.

Dr. W. R. Townsend presented a case of this kind, which had been exhibited to the Society about one year ago. It was a case of infantile cerebral palsy. Instruments had been used at the time of birth, but no damage had apparently been done to the exterior of the skull. The boy had never been able to use the right hand, and had a typical "claw hand" when he came under observation at the age of fifteen years. On December 21, 1899, an incision had been made over the wrist, exposing the tendons. The flexor carpi radialis, the flexor carpi ulnaris and palmaris longus were divided just above the annular ligament. The hand was then turned over and an incision made on the dorsum of the wrist, and the extensor communis digitorum exposed. A dissection having been made through the interosseous space, the extensor tendon was pushed through, and being too long, was doubled upon itself. It was then attached to the tendons previously mentioned. The union of the tendons had been satisfactory and permanent. The tendons had not shown any tendency to unite to the surrounding tissues. He was now able to write fairly well, whereas formerly he could not even grasp a pen.

Dr. B. Sachs said that he had been deeply interested in this subject, and it was certainly the best procedure that had been suggested for these cases of contracture whether of spinal or cerebral origin. The problem was to split the tendons of the over-acting muscles and unite them to the tendons of the under-acting muscles, and so restore the equilibrium of power. It had been found prudent not to allow the patient to exercise much or to use electricity until the tendinous union had become very firm. It was unfortunate that this boy was not able to extend his fingers, yet he had secured good extension of the wrist. In spite of the tendon transplantation the boy experienced no difficulty in producing flexion when he desired to do so.

Dr. Schlapp remarked that it seemed to him that the boy's hand was decidedly larger now than when he had seen the case a few months ago.

CUTANEOUS LESIONS WITH NEUROTIC SYMPTOMS.

Dr. Creighton presented a young woman of neurotic temperament who, four years ago, had had hysteria and typical attacks of grand mal. One year ago she had had the grippe, followed by pneumonia, and this had been succeeded by headaches, aching spine and numbness in the left side. There were severe contractures in the left arm. A small painful tumor had appeared in the left palm, and had been removed by the family physician under cocain. It had returned, and had been again removed. A galvanic current of 10 milliamperes had brought out a slight redness on the palm. Three days before menstruation a large red spot had appeared on the back of the forearm, and soon afterward several similar spots had made their appearance on the arm. A few days before the next menstruation these spots had returned, and in addition, a number of large blotches appeared on the left shoulder, and left side of the neck. The whole side was very hyperesthetic. There was slight narrowing of the visual field, and there was left-sided sweating. The speaker said that the case was very similar to one recently reported from Erb's clinic.

Dr. Joseph Fraenkel asked whether there had been a history of malaria, and whether the case might not be looked upon as one of morphea.

Dr. Creighton replied that there was no history of malaria, and the family physician had stated that the tumor which he had removed, grew on the nerve. The microscopical examination had been made at the laboratory of the Presbyterian Hospital, and the report had been that there was a slight round-cell infiltration only; no nerve degeneration was found. The thyroid gland was not enlarged.

Dr. C. L. Dana said that he had seen cases presenting just this appearance, but entirely free from hysteria.

Dr. W. B. Noyes said that several skin lesions were closely associated with nervous troubles. Herpes zoster, erythema multiforme and Raynaud's disease were distinctly related to the nervous system, yet it was very difficult to state the exact relation. It had occurred to him that the element of suggestion regarding the connection with the nerve might be responsible for some of the phenomena present.

Dr. E. D. Fisher said that this could not be properly described as simple hysteria, or as the result of mere suggestion. The eruption was not characteristic of an hysterical state.

Dr. M. G. Schlapp said that these cases had been described before; they had been brought on by suggestion. In this case an injection had been given in the arm, and shortly afterward this dermatitis had first appeared. The eruption was not characteristic of any particular skin lesion, but it closely resembled cases that had been described as hysterical skin manifestations. In typical zoster there was frequently a degeneration of the nerve fiber itself.

Dr. Sachs said that the case was a very unusual one, and he did not regard it as belonging to the class of hysterical hyperemia. It was certainly a distinct form of skin neurosis. The closest resemblance in the anatomical distribution was to herpes.

Dr. Joseph Collins said that if the girl should develop a pneumonia he would not be willing to call it a hysterical pneumonia; neither was he willing to call this a hysterical skin disease. He was inclined to think it was closely related to morphea.

Dr. Creighton said that a case had been reported very recently in which the gangrenous form had ultimately developed. This case had been described as hysterical. Dr. J. C. Johnston, the dermatologist, had seen this patient, and had looked upon it as hysterical.

PARALYSIS OF THE SPINAL ACCESSORY.

Dr. Pearce Bailey read this paper. He said that the chief interest of this nerve was surgical. Within the past year two instances had come to his notice of accidental section of the nerve. In most cases the paralysis which resulted from section was not particularly disabling, but such had not been the case in the instances referred to. When the sterno-mastoid was completely paralyzed the freedom of movement of the head was interfered with, but not totally abolished. In the two cases referred to the disability had been unusually great, and had led him to study more carefully the nerve supply. It was now regarded as a spinal nerve, pure and simple. The spinal portion of the nerve, represented by the external branch, springs from the upper five segments of the cord. Paralysis of the nerve presents a varying symptomatology according to the site of the lesion. An injury outside of the skull to cause symptoms referable to both branches must be situated directly at the base of the skull. The extracranial lesions of the spinal accessory nerve are confined to the external branch, and are nearly always traumatic. Neuritis in this nerve is rare. A case was cited to illustrate the possible traumatic origin of spinal accessory palsy by injury with a blunt instrument. In two cases reported the paralysis had been directly the result of operation. In the second case the resulting incapacity had been so great that the right arm had been rendered practically useless for any heavy work. Neurorrhaphy had been performed about six weeks after the operation at which the nerve had been injured, and the ends of the divided nerve had been found separated over one inch. The improvement in motor power had been slow. A reference to the literature showed conflicting views regarding the nerve supply. Dr. Bailey said that the spinal center between the first and fifth cervical segments of the cord was fixed and constant, but occasionally all the axones pass to the muscle by the spinal accessory. Under these circumstances the motor impulses reach the trapezius through the spinal accessory, and hence, section of it means total palsy.

Dr. W. M. Leszynsky said that he had seen a patient two months ago who had been operated upon for torticollis. Over one inch of spinal accessory nerve had been removed on the left side without relief, and the function of the muscle had remained perfectly normal. He had seen over an inch of the other spinal accessory nerve removed subsequently, yet the muscle had not been affected at all; hence he had held that it was useless in these cases of spasm to operate upon the spinal accessory nerve.

Dr. J. Arthur Booth said that he had had a case of spasmodic torticollis operated upon by section of the spinal accessory nerve. A little more than one inch had been excised, and the sterno-mastoid and part of the trapezius had been paralyzed as a result.